Manitoba
Attorney General

OFFICE OF
THE
CHIEF MEDICAL EXAMINER

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HISTORICAL BACKGROUND

(Coroner System - Medical Examiner System)

The Medical Examiner and the Medical Examiner system has evolved from duties which were assigned to Coroners and systems put in place to effect the legislated and non-legislated responsibilities of the office.

The word coroner is a derivation from the old French spelling of the word "crown". The office of "Crowner" (crown representatives) was originally established to secure revenues which accrued to the crown in the event of sudden or unexplained deaths.

The first detailed statute on the office of coroner was the 1275 Statute of Westminister which established the office for revenue purposes. Subsequent British legislation shifted the coroner's responsibility to the investigation of deaths due to violence or unnatural means but retained the revenue aspect through a fee payable to the coroner for each inquest held.

Historically, Canada inherited the concepts of a Coroner and of a Coroner's inquest as part of the common law. The common law powers of a coroner to indict persons upon an inquisition for murder or manslaughter, to commit them for trial and to certify evidence were incorporated as part of the Canadian Criminal law in 1892, at which time the indictment function of the inquest was terminated.

The subsequent enactment of Provincial legislation established the jurisdiction and role of the Coroner and continued the coroner's functions of investigating deaths, empanelling juries and conducting inquisitions (inquests). In some provinces and territorial jurisdictions the coroner concept still remains.

With the advancement of the Forensic Sciences and Pathologists specially trained in Forensic Medicine, it seemed logical that with a bulk of reportable cases being medical in nature that, instead of reporting to Lay Coroners, that the reporting be done to qualified medical persons. From this evolved the Medical Examiner System.

It was as recently as 1971 that Manitoba enacted and proclaimed THE FATALITY INQUIRIES ACT to replace THE CORONER'S ACT. This statute was re-enacted in 1975 and again in 1987 and remained in effect until May 14th, 1990, when a new FATALITY INQUIRIES ACT was proclaimed.

The distinct features of the current Act are the division of responsibilities into the medical and legal disciplines; the initial inquiry into the cause and manner of death being carried out by a duly qualified medical practitioner; and the inquest, when deemed necessary, being conducted by a Provincial Judge without a jury.

This brief historical background has been provided to explain that in Manitoba the Medical Examiner system, while relatively recent in origin, has been both legislatively and operationally implemented and has fully replaced the Coroner system.

INTRODUCTION

The Office of the Chief Medical Examiner in Manitoba is responsible under the Fatality Inquiries Act and the Vital Statistics Act for the inquiry/investigation and certification of all deaths by violence, as well as unexpected, unexplained or unattended deaths. Certain hospital and institutional cases, notably those of persons dying within ten days of surgery or anaesthesia, or within 24 hours of admission, are investigated, as are deaths of persons held involuntarily, and residents of personal care homes. Also, in the event of the death of a child - in-care the Chief Medical Examiner shall review the actions taken by the Child and Family Services agency.

The area of jurisdiction is the province of Manitoba, which has a population of approximately 1.1 million. In addition, the Medical Examiner has jurisdiction over those who travel through the province.

The medical examiner system, under the direction of the Chief Medical Examiner, is managed from a central office located in Winnipeg. The office administers the complete province of Manitoba and has a permanent staff of one administrative officer, three medical investigators and three administrative secretaries. The fee-for-service element is provided by approximately 70 part-time medical examiners with additional fee-for-service support provided by pathologists, funeral directors and ambulance services.

In the City of Winnipeg, three medical investigators are on duty daily Monday to Friday during standard working hours. Part-time medical examiners are available and on call during the evenings and weekends. Throughout rural Manitoba and in other cities such as Brandon, Thompson, etc., part-time medical examiners are available on an as-required basis 24 hours a day.

Toxicology testing is provided by the Royal Canadian Mounted Police Forensic Laboratory. Other speciality tests are provided on an as-required basis, utilizing outside resources both in and out of the Province of Manitoba.

In 1988, 2541 deaths were investigated by the Chief Medical Examiner's office. This represented twenty - eight per cent of all deaths in Manitoba during the year. In each case, the report generated by the medical examiner or medical investigator contained information on the cause, manner, identity and age of the deceased, and circumstances surrounding the death. In many cases the police, both RCMP and municipal forces, assist the medical examiners in conducting their investigations.

In January of 1985, the Office of the Chief Medical Examiner became actively involved in the eye donor program. Next of kin were contacted shortly after death and asked to consent to donating the cornea of the deceased. Through the program, regular donations were made available to the Lions Eye Bank.

Appreciation is expressed to all Law Enforcement Agencies and all other related agencies involved who have, throughout the year, cooperated and assisted in the investigations which have been processed through this office. Also , gratitude is expressed to all Medical Examiners who have shown a high level of dedication, and professionalism, frequently under adverse conditions.

Caseload Statistics

TOTAL CASES

CERTIFIED CASES

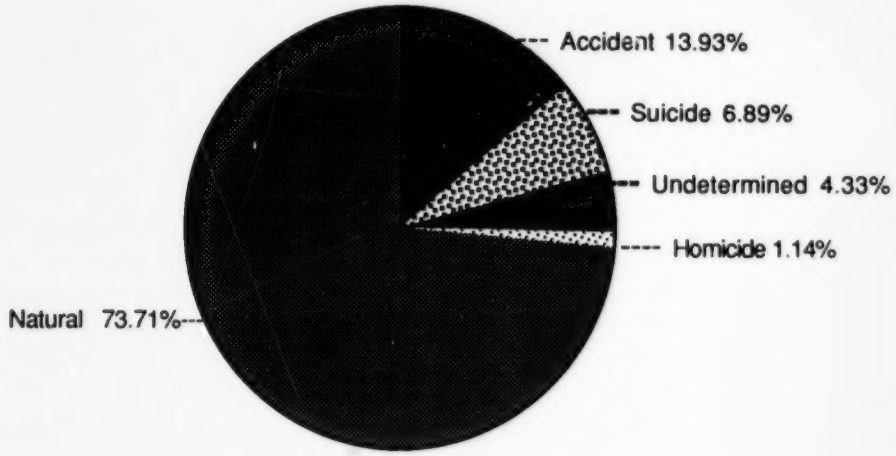
Manner of Death	Cases	Aggregate Rate per 100,000 population
Natural	1873	172.8
Accidents:		
in the Home	98	9.0
in other Places	82	7.6
Industrial	18	1.7
Motor Vehicle	156	14.4
Suicides	175	16.1
Homicides	29	2.7
Undetermined	110	10.1
Total	2541	234.4

Note: 422 natural deaths were designated Medical Examiner's Investigators cases.

REGIONAL DISTRIBUTION OF CASES

	Urban	Rural	Total
Natural	1423	450	1873
Accidents:			
in the Home	65	33	98
in other Places	24	58	82
Industrial	5	13	18
Motor Vehicle	59	97	156
Suicides	111	64	175
Homicides	17	12	29
Undetermined	78	32	110
TOTAL	1782	759	2541

MEDICAL EXAMINER CASES



CASELOAD REVIEW 1972 - 1988

YEAR	TOTAL
1972	2320
1973	2409
1974	2409
1975	2604
1976	2653
1977	2758
1978	2667
1979	2627
1980	2480
1981	2683
1982	2480
1983	2545
1984	2386
1985	2522
1986	2605
1987	2503
1988	2541

TYPES OF DEATH INVESTIGATED AND CERTIFIED

HOMICIDES

	Male	Female	TOTAL
Urban	12	5	17
Rural	7	5	12
TOTAL	19	10	29

AGE/METHOD

Method	Age: 0-9	10-19	20-29	30-39	40-49	50-59	over 60	TOTAL
Police	0	0	0	0	0	0	0	0
Blunt Weapon/ Violence	0	0	3	3	1	0	3	10
Firearms	0	0	1	2	1	1	1	6
Stabbing/ Incised Wound	0	1	2	4	1	2	1	11
Child Battery	0	0	0	0	0	0	0	0
Other	1	0	0	1	0	0	0	2
TOTAL	1	1	6	10	3	3	5	29

SUICIDES

SEX Age:	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	>80	TOTAL
MALE:										
NON-NATIVE	0	7	31	17	16	8	17	12	4	112
NATIVE	0	7	15	3	1	0	0	0	0	26
FEMALE:										
NON-NATIVE	0	0	5	10	3	3	1	1	1	24
NATIVE	0	5	3	4	0	0	1	0	0	13
TOTAL	0	19	54	34	20	11	19	13	5	175
RATE/100,000 POPULATION	0	1.75	4.98	3.14	1.85	1.01	1.75	1.20	0.46	16.14

REGION/MONTH

Month of Death	Urban	Rural	TOTAL
January	9	2	11
February	6	3	9
March	6	4	10
April	9	7	16
May	10	8	18
June	11	10	21
July	9	4	13
August	9	7	16
September	14	8	22
October	9	5	14
November	10	5	15
December	9	1	10
TOTAL	111	64	175

SUICIDE RATES PER 100,000 POPULATION BY YEAR

Year	Estimated Population (000's)	Total Suicides	Rate/ 100,000
1973	996.2	124	12.5
1974	1,007.5	141	14.0
1975	1,013.6	141	13.9
1976	1,021.5	141	13.8
1977	1,027.4	179	17.4
1978	1,032.0	155	15.0
1979	1,028.0	135	13.1
1980	1,024.9	126	12.3
1981	1,026.2	151	14.7
1982	1,034.5	149	14.4
1983	1,048.1	172	16.4
1984	1,058.8	151	14.3
1985	1,070.6	141	13.2
1986	1,071.2	168	15.7
1987	1,080.3	172	15.9
1988	1,084.0	175	16.1

METHOD

	Male	Female	TOTAL	PERCENTAGE OF TOTAL
Drug overdose/Poison	18	14	32	18.3%
Carbon monoxide	13	2	15	8.6%
Hanging/Strangulation	40	9	49	28.0%
Drowning	2	2	4	2.3%
Firearms	58	2	60	34.3%
Jumping	7	2	9	5.1%
Other	0	6	6	3.4%
TOTAL	138	37	175	100%

NATIONAL SUICIDE RATES* PER 100,000 POPULATION 1978 - 1988

	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988
National Rate	14.8	14.1	14.0	14.0	13.9	15.1	13.7	12.9	14.5	14.0	13.5
NFLD	02.6	04.4	03.4	04.2	06.0	06.2	06.7	04.0	04.0	04.9	7.7
PEI	13.1	13.1	11.4	07.4	08.9	12.9	12.0	03.9	11.1	08.6	10.1
NS	12.5	12.6	11.5	10.9	12.2	12.1	09.9	12.0	10.8	12.6	12.0
NB	12.9	12.1	11.6	11.1	12.9	14.2	12.6	12.0	13.5	10.5	15.1
QUE	14.2	15.4	14.8	16.4	16.5	18.5	15.7	17.1	17.6	17.9	16.4
ONT	14.3	13.0	13.1	12.5	12.7	12.9	12.3	11.4	12.4	11.5	11.1
MAN	15.4	14.7	11.8	14.0	13.4	15.8	12.7	11.9	14.3	15.8	14.2
SASK	17.3	14.9	15.9	17.7	17.5	14.9	13.5	13.0	13.7	13.0	14.3
ALTA	16.5	15.4	18.1	15.9	16.2	16.7	17.2	12.6	17.9	16.1	16.7
BC	18.3	16.2	14.8	14.5	15.0	14.8	13.4	10.4	14.7	14.1	12.7
YUKON**	03.2	02.7	05.0	02.2	02.9	03.6	02.3	03.5	04.3	02.8	02.8
NWT**	05.5	01.8	02.0	02.2	01.7	04.3	03.4	02.5	02.9	02.9	04.0

* Source: Statistics Canada

** Rates based on 10,000

TRAFFIC ACCIDENTS

Motor Vehicle

- Alcohol related	74
- Not alcohol related	82
TOTAL	156

Vehicle/Pedestrian	31	Vehicle/Train	1
Vehicle/Vehicle	48	Vehicle/Fixed object	0
Single vehicle	54	Multiple vehicle	0
Snowmobile	3	Motorcycle	4
All terrain cycle	2	Vehicle/Motorcycle	5
Minibike/Off road	1	Vehicle/Cyclist	6
Motorhome	0	Other	1

TOTAL TRAFFIC FATALITIES 156

NON-TRAFFIC ACCIDENTS

A. INDUSTRIAL

Farming	5
Mining	4
Other	9
TOTAL	18

B. IN OTHER PLACES

Aircraft	2
Exposure	8
Drowning	31
Carbon monoxide poisoning	1
Falls	9
Hunting	0
Falling objects	1
Other	30
TOTAL	82

C. IN THE HOME

Falls	35
Asphyxia	13
Inhalation burning house	23
Burns/Scalding	5
Electrocution	0
Drugs/Alcohol	11
Inhalation (Sniffing)	1
Cafe Coronary	3
Other	7
TOTAL	98

Total non-traffic accidents	198
TOTAL ACCIDENTAL DEATHS	**354**

NATURAL DEATHS

CAUSE OF DEATH	MALE	FEMALE	TOTAL
Heart Disease	695	374	1069
Cancer	72	50	122
Lung Disease	105	75	180
Haemorrhage	96	74	170
Intra - Operative	14	5	19
Post - Operative	64	72	136
Stillborn	1	0	1
Undetermined	24	9	33
Other	78	65	143
TOTAL	1149	724	1873

AGE GROUP	MALE	FEMALE	TOTAL
under 1 year	9	6	15
1 - 9	3	6	9
10 - 19	3	1	4
20 - 29	18	8	26
30 - 39	21	14	35
40 - 49	49	27	76
50 - 59	125	44	169
60 - 69	284	142	426
70 - 79	390	218	608
80 - 89	207	203	410
90 - 99	32	44	76
over 100 years	1	2	3
unknown	7	9	16
TOTAL	1149	724	1873

REPORTS ON CHILDREN - IN - CARE AT TIME OF DEATH

YEAR	MALE	FEMALE	TOTAL
1987	4	7	11
1988	9	3	12

SUDDEN INFANT DEATH SYNDROME

AGE GROUP	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
O - 4 Months	1	1	0	0	2	1	1	0	1	1	1	1
5 - 8 Months	1	1	1	0	0	0	0	0	1	0	0	0
9 - 12 Months	1	0	0	0	0	0	0	1	0	1	0	0
TOTAL	3	2	1	0	2	1	1	1	2	2	1	1

In Manitoba S.I.D.S. accounted for 17 infant deaths in 1988. The overall incidence of S.I.D.S. has been reported as 1 case per 1,000 live births. Although it can occur at any time during the first year of life, the peak incidence in Manitoba is during the first four months.

S.I.D.S. STATISTICS 1975-1988

1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988
31	32	34	24	21	23	34	22	28	22	23	22	13	17

UNDETERMINED* DEATHS

CAUSE OF DEATH	MALE	FEMALE	TOTAL
Asphyxia	5	4	9
Carbon monoxide poisoning	2	2	4
Drowning	3	0	3
Drugs/Alcohol overdose	9	12	21
Falls	0	1	1
Exposure	2	0	2
Other	35	18	53
TOTAL	56	37	93

* Undetermined whether accidental, suicide, or homicide

INQUESTS

INQUESTS SUMMARY

(January 1, 1988 - December 31, 1988)

Judicial Recommendations For the Prevention of Similar Deaths

Manner of Death	Given	Not Given	Not Available	
Natural	0	0	0	
Homicide	0	0	0	
Suicide	0	3	2	
Accident	12	6	2	
Undetermined	0	2	0	
TOTAL	12	11	4	**27**

TYPE OF INQUESTS

A. HOSPITAL/INSTITUTIONAL RELATED

Accidental	1
Suicide	1
Natural	0
TOTAL	2

B. OCCUPATIONAL RELATED

Accidental	8
TOTAL	8

C. POLICE/INCARCERATION RELATED

Suicide	2
Undetermined	0
Accidental	3
Homicide	0
TOTAL	5

D. SPORTS/RECREATIONAL RELATED

Accidental	1
TOTAL	1

E. OTHER

Undetermined	2
Accidental	7
Suicide	2
TOTAL	11

TOTAL INQUESTS 27

Summary of Inquests and Recommendations

(All deaths occurred in 1988)

Case	Description	Judicial Recommendations
1. Multiple injuries and trauma	Accidental. Deceased was working alone at the zoo, taking care of camels in an enclosed area. He was attacked by a male camel which was in rut at the time.	1) That those who work with animals, especially zoo keepers, be aware that in certain times of their lives, animals can become erratic and dangerous. They should, therefore, never work in close proximity to these animals if their behaviour does not appear normal.
2. Hypothermia	Accidental. Deceased ran from a friend's car across a field, attempting to return to the scene of a house party he was at earlier. He was inappropriately dressed and impaired by alcohol. He was also alleged to have taken other drugs.	None.
3. Hypothermia	Accidental. Deceased had been under the care of the Awasis Agency. He had been dropped off near his house, extremely intoxicated, and was found frozen to death at the same place the next morning.	1) That the procedure for transportation of wards of Awasis be changed formally, perhaps including training of some sort. 2) That future court hearings involving Awasis wards be held in the home community, where possible.
4. Gunshot wound to chest	Accidental. Deceased suffered gunshot wound to the chest during confrontation with a police officer.	1) That a study seminar for Provincial Court Judges be arranged to consider Inquest procedures and possible amendments to the Fatality Inquiries Act.

Case	Description	Judicial Recommendations
		2) That the City of Winnipeg develop a program in an effort to recruit Natives and members of other visible minorities to mitigate distrust shown to WPD by these groups.
5. Head and chest trauma	Accidental. Deceased was operating heavy machinery in open-pit mine at Ruttan when the vehicle flipped over, pinning him beneath the cab.	1) That there be no undercutting. 2) That all existing overhangs and ridges be blasted, as well as having them safety drilled. 3) That any rock 90% horizontal to ridge and not parallel to it be ripped or broken up.
6. Rupture of heart and aorta with exsanguination	Accidental. Deceased was a miner driving a drift with his partner. He had gone in 54 feet when a 2500 lb rock slab came down as they were preparing to blast. Deceased died instantly of severe crush injuries.	1) That all contractors be required to meet the minimum requirements of the mine operator. 2) That the Mines Inspector be empowered to require immediate compliance with #1.
7. Hypoxic/ischemic brain damage	Accidental. Deceased was a Down's Syndrome child who had gone swimming at Sherbrooke Pool with his teacher and 25 other students. Drowned accidentally.	1) That the City of Winnipeg and other operators of public swimming pools in Manitoba be required to determine immediately the suitability and effetiveness of the use of mechanical resuscitation equipment. 2) That the City of Winnipeg and other public pools review their policies regarding requirements for "spotters" or "lookouts" at organized swim programs where staff from the schools may be available to act as the above-mentioned spotters or lookouts.

Case	Description	Judicial Recommendations
		3) That the City of Winnipeg and other public pools review their policies as to the commencement of artificial respiration by lifeguard/ instructors upon submersion victims still in the water, or whether the first priority should be to get the victim to the pool deck for the procedure If expert advice so dictates, pool policy should make a distinction between submersion victims found in shallow as opposed to deep water.
8. Asphyxia, hanging	Suicide. Self-inflicted asphyxia by hanging.	Not available.
9. Methanol poisoning	Accidental. Deceased attended a BBQ with friends, where everyone drank from a vodka bottle thought to be ethanol, but which turned out to be methanol.	Not available.
10. Consistent with drowning.	Accidental. Deceased was a robbery suspect who jumped into the Assini-boine River while police were in pursuit. Police officers saw deceased swim 3/4 of the way across river, then go under water.	None.
11. Asphyxia	Accidental. Deceased was an attendant at a city landfill site. A wooden trailer was blown on top of the deceased by extremely high winds.	1) That all City of Winnipeg trailers used at landfill sites and other similarly open areas be equipped with stabilizing legs at all corners.

Case	Description	Judicial Recommendations
		2) Manitoba Regulation 189/85 being a regulation under the Workplace Safety and Health Act respecting the construction industry be amended to require specifically that all trailers located at construction sites be stabilized in a manner which will prevent them from being overturned by windspeeds up to 70 mph.
12. Multiple traumatic injuries	Accidental. Deceased was struck by roller coaster as he attempted to get off the track and out of its path. He was apparently reaching for a package of cigarettes which had fallen onto the track.	None.
13. Gunshot wound to the head	Suicide. Two brothers committed suicide in the same manner less than 2 months apart. Inquest called due to allegations that the two had been abused.	Not available.
14. Drowning	Suicide. Patient under care in psychiatric ward left without permission; later found in Red River near Metcalfe Ave.	None.
15. Bilateral pulmonary aspiration of gastric contents	Accidental. Deceased was placed in an isolation room at Selkirk Mental Hospital on 21/07/88 at 08:00. He was checked upon every 15 minutes, as is their policy, but was discovered dead at 11:45 the same day.	Not Available.

Case	Description	Judicial Recommendations
16. Septicemia; Gunshot wound to abdomen	Undetermined. Events unclear, but apparently the deceased was attempting to rob a store when a scuffle ensued and he was shot by his own weapon.	None.
17. Renal failure and cerebral anoxia	Undetermined. Deceased suffered cerebral anoxia when she attempted suicide (found hanging in her cell). She remained comatose until her death five years later.	None.
18. Cardiac arrest due to cocaine intoxication	Accidental. Deceased was walking in the middle of the street in a bizarre manner. Police tried to get him off of the road, but he collapsed and arrested when he was handcuffed.	1) That police officers, ambulance personnel and others who are responsible for protecting the public ought to be taught and trained to recognize as quickly as possible a person who may be suffering from cocaine- induced (as opposed to alcohol- induced) intoxication. Once cocaine intoxication is suspected, the patient should be taken to a medical facility as soon as possible.
19. Exsanguination due to crush injury	Accidental. Deceased was working as a mechanic at Ruttan Mine when he was crushed against a mine wall by a piece of heavy equipment.	None.
20. Pulmonary edema due to drug toxicity.	Suicide. Deceased, a known hemophiliac and on psychotic medication, was found on bedroom floor. Self-administered lethal dose of anti-psychotic medication.	None.
21. Strangulation	Suicide. Deceased hanged himself with prison towel by	None.

Case	Description	Judicial Recommendations
	attaching it to a conduit pipe near the ceiling in his cell at Stoney Mountain Penitentiary.	
22. Inhalation of combustion products followed by almost complete incineration of the body	Accidental. Fire of unknown origin broke out in the hotel where the deceased resided.	1) That the Office of the Fire Commissioner tighten its inspection procedure and where flagrant and dangerous violations of the Fire Code of Manitoba are detected (as in this case), owners should be given a reasonable time period in which to comply. Failure to do so should result in prosecution. In extremely dangerous cases, the premises ought to be closed until changes are made.
23. Burns (extensive), smoke inhalation	Accidental. Deceased was a child caught in a house fire which was likely to have been started by himself. Family unable to locate child in house before smoke inhibited search.	None.
24. Multiple injuries	Accidental. Deceased and two others fell to the ground while painting the ceiling of a curling rink.	None.
25. Fatal head injury	Accidental. Deceased found at landfill site. His injuries were consistent with being struck in the head area by a very large and heavy object.	1) That those who are responsible for for the workplace program (assumed to be in a position to revise policy) should review ways in which areas of potential danger in any industrial sector may be made safer for workers.
26. Cardio-respiratory arrest	Accidental. Deceased got stuck in basement window. Upon discovering that she	1) More training should be provided for people who receive incoming calls at the police station.

Case	Description	Judicial Recommendations
	was locked out, deceased tried to enter house via window and asphyxiated.	2) Guidelines for police personnel taking incoming calls from the public should be improved; more specifically, if there is a clear request for medical attention and if the call is deemed serious by the person taking the call, the nature of the situation and location of call should be assessed and help dispatched (if necessary) immediately. 3) Investigating officer should be required to ensure that next-of-kin are notified of the death of the family member.
27. Multiple organ failure	Accidental. Deceased was crushed in a mining accident that occurred on the job, in which he was crushed between a cable and a conveyor belt.	1) A second person should be supplied to act as a switchman before any trains begin moving down track. 2) All trammers utilized within the mining industry, whether they hinge or are of the slide rail styles, should be equipped with locking devices of adequate strength to prevent crushing injuries upon impact under the most severe conditions.